

Self-Directed CFC/PAS Service Plan

<input type="checkbox"/> Intake <input type="checkbox"/> Annual <input type="checkbox"/> Amendment <input type="checkbox"/> Temporary Authorization <input type="checkbox"/> High Risk <input type="checkbox"/> Other				
MPQH Profile Date Span:			MPQH Total Profile Bi-Weekly Units (15 Minutes = 1 Unit):	
SERVICE PLAN SCHEDULE Member Name:			Medicaid ID Number:	
AM/PM	ADL Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	HMA Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	IADL Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	Skill Acquisition	Frequency Week One	Frequency Week Two	Comments
Total ADLHMA/ Units:		Total IADL Units:	Total Skill Acquisition Units:	Total Bi-Weekly Units:
COMMENTS AND SPECIAL INSTRUCTIONS FOR SERVICE PLAN IMPLEMENTATION:				
ACTION PLAN <i>(Utilized when member preferences cannot be met. Indicate agency plan and associated time line to address the situation)</i>				
TEMPORARY AUTHORIZATION/AMENDMENT <input type="checkbox"/> Change In Condition <input type="checkbox"/> Change In Task <input type="checkbox"/> Change In Task Frequency <input type="checkbox"/> High Risk <input type="checkbox"/> Addition Of Skills Acquisition				
DESCRIBE ADL/HMA/IADL CHANGE: <input type="checkbox"/> Short Term <input type="checkbox"/> Permanent				
TEMPORARY AUTHORIZATION: Start Date: End Date: Total Time: Date Faxed to MPQH:				
MEMBER: My Plan Addresses My Personal Assistance Needs, Including Health And Welfare.				
MEMBER/PERSONAL REPRESENTATIVE SIGNATURE			DATE	
<input type="checkbox"/> Concur <input type="checkbox"/> Do Not Concur				
PROVIDERS <input type="checkbox"/> This Service Plan Does Not Require Completion Of A Risk Negotiation Form <input type="checkbox"/> I Agree with the Amendment Request				
SD CFC/PAS PROVIDER SIGNATURE			DATE	
AGENCY				
PLAN FACILITATOR SIGNATURE			DATE	
AGENCY				